Cost-Saving Options for District Health Programs: Framework for a New Strategy

The District can save local dollars by increasing the proportion of District health expenditures billed to Medicaid. Though it may appear counter-intuitive, serving more people through Medicaid can save the District a significant amount of money. Each Medicaid dollar is matched by roughly three federal dollars; hence the importance of maximizing the use of Medicaid (rather than the Alliance and other programs funded with 100% local dollars) in the provision of health services. Thus, spending more on Medicaid (and a little less on the Alliance and other locally funded programs) would actually save the District a significant amount of local money.

Moving More Patients to Medicaid

A successful strategy may include the shift of many populations and services to the federally-funded Medicaid program. Several examples clearly illustrates this point:

1. **Expand Medicaid eligibility for the disabled.**

   D.C. Medicaid presently covers disabled and elderly adults up to 100% of the Federal Poverty Level (FPL), leaving many low-income disabled clients with incomes between 100% FPL and 200% FPL to seek services from the Alliance, which is 100% locally-funded. However, using arcane Medicaid provisions (known as §1902(r)2, §1931, etc.) the District could liberalize some of the conditions of financial eligibility for Medicaid, allowing the federally-funded Medicaid program to serve many disabled persons who would otherwise enroll in the Alliance. The net result would be an increase in the Medicaid-eligible disabled population and a corresponding decrease in the number of such consumers in the Alliance. By serving many of these high-cost individuals under Medicaid (with its attendant federal cost-sharing), the District would leverage substantial new federal Medicaid revenues (roughly $2 to $5 million annually).

2. **Extend Medicaid-funded prenatal services to non-qualified alien women.**

   This proposal would provide Medicaid to non-qualified alien pregnant women who would be eligible for Medicaid were it not for their alienage status. Currently, non-qualified alien women are served by the Alliance with 100% local funds while qualified aliens and citizens who are pregnant are served by Medicaid. This proposal would create a bright-line rule whereby all pregnant women would be served under Medicaid (and virtually none under the Alliance).

   Under the emergency Medicaid provisions of 42 CFR 440.255, D.C. Medicaid is already required to pay the labor and delivery costs of these women. This proposal simply extends a few months of eligibility to non-qualified immigrant women earlier in their pregnancy. In the absence of this SPA, these women would continue to be served by the Alliance with 100% local funds.

   Because of an arcane funding rule, this proposal is necessarily cost saving. Currently, the labor and delivery costs for non-qualified immigrant women are covered under emergency Medicaid and are reimbursed as a traditional Medicaid service at the District's 70% match rate. This SPA would secure the enhanced federal match (79%) for those costs. This new revenue alone would likely

cover the entire cost of the program – even without incorporating any of the savings that the Alliance would accrue. Thus, the availability of the new enhanced match revenues (the increase from 70% to 79%) for emergency services virtually guarantees that the SPA will be cost saving.

3. **Increase the Medicaid eligibility level for 19- and 20-year olds.**

   Currently, this group is covered by Medicaid up to 50% FPL. Nineteen- and 20-year old children between 50% and 200% FPL are served by the Alliance. This causes considerable confusion among many families and medical providers.

   Under this proposal, however, all children age 20 and under 200% FPL would be served under Medicaid. In so doing, the District would leverage the 70% federal Medicaid match rate for services provided to this group. This new federal Medicaid revenue may prove substantial: while these children are normally low-cost to cover, they can occasionally be expensive (e.g., trauma victims).

Streamlining Medicaid Eligibility

Currently, the Medical Assistance Administration (MAA) is reviewing a proposal to streamline the application process. Specifically, the proposal aims to standardize the income and resources definitions among the Medicaid, Food Stamp, and TANF programs. In doing so, the District would be able to reduce the current 18-page application to a new six-page form.

This proposal does entail some modest savings: analysts from MAA, IMA, and the OCFO reached a consensus that the District would save roughly $65,000 in local funds each year. However, the clear benefit is with a streamlined application process that will enable IMA to further reduce average processing time from a median of 12 calendar days. IMA remains ready to implement the new application process as soon as MAA completes the formal State Plan Amendment process.

Maintenance of Effort: Cause for Concern?

Concern has been raised about federal "maintenance of effort" (MOE) requirements and how these may limit Medicaid maximization strategies. Based on information from the Medicaid experts with whom we have consulted, the statutory MOE requirements are few in number, and these have very limited relevance to Medicaid expansion options described above.

When CMS officials raised concerns about the few applicable MOE requirements, states have found that these issues are subject to negotiation. Indeed, many heretofore state-funded health care programs (e.g., in Utah, Oregon, and Illinois) have essentially become new Medicaid programs that leverage federal Medicaid match – notwithstanding some of the earlier MOE objections by CMS. These states were able to package their proposals in such a way that mitigated the MOE concerns and were therefore able to win approval.